Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FORT DUNCAN MEDICAL CENTER
1203 LAKE WOODLANDS DR STE 4024
WOODLANDS TX 77380-5010

Respondent Name
LIBERTY MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-11-0717-01

MFDR Date Received
October 18, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual should have paid a total of $13,163.67, leaving a balance of $9,192.76 due and outstanding."

Amount in Dispute: $9,192.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment now Issued, EOB Enclosed."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2009 to October 31, 2009	Outpatient Hospital Services	$9,192.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
   - Z306 – SIGNIFICANT, SEPARATELY IDENTIFIABLE EVALUATION AND MANAGEMENT SERVICE BY THE SAME PHYSICIAN ON THE DAY OF A PROCEDURE.. (Z306)

Issues

1. Did the requestor timely file the request for medical fee dispute resolution?
2. Did the requestor submit the request in the form and manner required by §133.307?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1), effective May 25, 2008, 33 *Texas Register* 3954, states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." Per 28 Texas Administrative Code §102.3(a)(3), effective April 28, 2005, 30 *Texas Register* 2396, "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." The request for dispute resolution of services rendered on dates of service October 5, 2009 through October 16, 2009 was received by the Division on October 18, 2010. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). However, the Division notes that October 16, 2010 was a Saturday and not a working day per §102.3(a)(3). The next working day was October 18, 2010. The Division therefore concludes that the requestor has failed to timely file this dispute for services performed from October 5, 2009 through October 15, 2009 with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these services. Therefore service dates October 5, 2009 through October 15, 2009 will not be considered in this review. The Division concludes that the request for dispute resolution of services rendered on October 16, 2009 through October 31, 2009 were submitted in accordance with the timely filing requirements of §133.307(c); therefore, service dates October 16, 2009 through October 31, 2009 will be considered in this review.
2. 28 Texas Administrative Code §133.307(c)(2) requires that the provider "shall complete the required sections of the request in the form and manner prescribed by the Division." §133.307(c)(2)(E) further requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the documentation submitted by the requestor finds that the requestor has not provided copies of any medical records. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
3. Review of the submitted information finds insufficient medical documentation of the health care provided to the injured worker to support the disputed services as billed. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	August 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box

17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.